GENERAL HOUSEKEEPING

Please note the following:

All participants will be muted on entry

To speak to the group, remember to unmute yourself:

1. If you are connected through the computer audio, click the mic in the lower left hand corner of your screen to unmute and mute.
2. If you are connected through the phone press *6 to unmute and mute

Be sure to mute yourself when you are not speaking

Please do not place call on hold

Use the chat box, if you would like a moderator to call on you or share your comments with the group
AGENDA FOR TODAY’S MEETING

Welcome and Announcements

Social Determinants of Health Screening Tool Discovery & Development

1. Health Leads Screening Toolkit and Best Practices in Implementation of SDoH Screening
   • Michelle Zambrano, Manager of Special Programs, Health Leads, NY

2. Collaborative Examples of SDoH Screening
   • Colleen Senterfitt, CNM, Director Women's Health, Commonwealth Care Alliance
   • Gina Burrows RN, MSN, APRN, NEA-BC, Director Population Health, and Billie-Jo Frazier, MA, Manager Population Health, Connecticut Hospital Association

Developing our Outreach and Publication Plan for the Birth Equity for Moms and Babies Consensus Statement

Discussion

Closing Business

Adjourn
MEETING GOALS

- Share examples of SDOH screening tools to members
- Present strategies on how to implement an SDOH toolkit
- Develop a plan for further outreach and publication for the birth equity consensus statement
### CONNECTING OUR WORK TO THE STRATEGIC MAP

**PREMATURITY COLLABORATIVE STRATEGIC MAP**

**ACHIEVE EQUITY AND DEMONSTRATED IMPROVEMENTS IN PRETERM BIRTH**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase effective use of evidence-informed clinical and public health practice</td>
<td>Expand discovery and accelerate translation and innovation</td>
<td>Align multi-level support to improve health equity</td>
<td>Develop and implement messaging, policy &amp; practice strategies</td>
<td>Secure the funding and resources required for success</td>
</tr>
<tr>
<td>The Clinical and Public Health Practice Workgroup has the following objectives.</td>
<td>The Research Workgroup has the following objectives.</td>
<td>The Health Equity Workgroup has the following objectives.</td>
<td>The Policy and Communications Workgroup has the following objectives.</td>
<td>The Funding and Resources Workgroup has the following objectives.</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Optimize public health systems and strategies to improve the health of women and adolescents</td>
<td>Implement public health/community-based research and program evaluation</td>
<td>Foster and support community/place-based leadership and engagement</td>
<td>Tell the right story to each audience in a compelling way</td>
<td>Align and strengthen staffing and infrastructure</td>
</tr>
<tr>
<td>Optimize clinical practices to improve the health of women and adolescents</td>
<td>Expand basic, translational, clinical and health services research</td>
<td>Foster and support population-based solutions</td>
<td>Coalesce partners to support common messaging</td>
<td>Identify, cultivate relationships and prioritize potential funders/resources</td>
</tr>
<tr>
<td>Support strategies to increase the intentionality of pregnancy</td>
<td>Research effective adaptation and implementation of evidence to improve precision</td>
<td>Align federal, tribal, state, territorial, local and community policy initiative</td>
<td>Integrate messaging with other campaigns/efforts</td>
<td>Improve “asks” to secure funding and coordinate where appropriate</td>
</tr>
<tr>
<td>Ensure all women receive high quality prenatal care</td>
<td>Provide career support for multi-level/multi-degree investigators</td>
<td>Partner across sectors to impact the root causes of inequity</td>
<td>Engage partners to advocate policies supporting preterm birth goals</td>
<td>Provide appropriate funder and partner recognition</td>
</tr>
<tr>
<td>Ensure appropriate care for all women with prior preterm birth</td>
<td>Foster collaborative community learning</td>
<td>Establish a federal home for preterm birth efforts</td>
<td>Align payment/funding with desired outcomes</td>
<td></td>
</tr>
</tbody>
</table>

**Emphasize the health of women and adolescents**

Engage families, communities and other strategic partners across sectors through a collaborative infrastructure

Optimize the use of data and evaluation to drive learning and success
UPDATES
KELLOGG GRANT: LAYING THE GROUNDWORK

Funding for the Collaborative Health Equity workgroup (2017-2019)

• Support for Health Equity Director
• Completion of workgroup products:
  • Guiding Principles to Achieve in Preterm Birth
  • Birth Equity Consensus Statement for Moms and Babies
    ➢ Consensus statement dissemination plan including manuscript submission to AJPH (2019)
• Resource sharing via website rather than new directory
• Presentations at CityMatCH and APHA
KELLOGG GRANT: BUILDING ON EXISTING OPPORTUNITIES

Expanded Opportunities

• New joint workgroup activities, including SDOH screening tools

• Enhanced focus on March of Dimes equity messaging and professional education via Frameworks project & implicit bias training

• Upcoming Health Equity Forum
  • Next in-person convening of select Collaborative members
  • Focus on strengthening local collaboratives using collective impact/action and Results Based Accountability
HEALTH EQUITY FORUM

- Save-the-Dates have gone out! If you haven’t received a Save-the-Date, please email us at collaborative@marchofdimes.org.

AGENDA:
9:00 Welcome
9:15-10:15 Opening Plenary- Dr. Zea Malawa, SF County Public Health & Expecting Justice
10:30am-12:00 –Implicit bias training- March of Dimes new Implicit Bias Training
12:00-12:45 networking lunch
12:45-3:45 Collective Impact & Results Based Accountability Training-
   Dr. Michael McAfee, CEO, PolicyLink
3:45-5:00 Fireside Chat Panel:
   Rev. Tommy Rodgers, Bethlehem Baptist Church & Healthy Start, Abbie Gilbert, Humana (Invited) & Bernadette Kerrigan, First Year Cleveland (Invited)
SOCIAL DETERMINANTS OF HEALTH SCREENING TOOL DISCOVERY & DEVELOPMENT
HEALTH LEADS SCREENING TOOLKIT AND BEST PRACTICES IN IMPLEMENTATION OF SDOH SCREENING

MICHELLE ZAMBRANO
MANAGER OF SPECIAL PROGRAMS, HEALTH LEADS, NY
Best Practices in Screening for Essential Needs

March of Dimes Prematurity Collaborative
Health Equity Work Group 3.28.19

Michelle Zambrano
Manager of Special Programs
OUR VISION: Health, well-being and dignity for every person in every community.

OUR MISSION: We partner with communities and health systems to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.
Our Experience

22 years of experience focusing on essential needs (social determinants of health)

Deep experience navigating intersection of healthcare systems and communities

Expertise in essential resource programming, implementation and evaluation

Focus on the impact of oppression, inequity and lived experiences of people and communities

Note: Based on feedback from patients, the preferred term is “essential needs”
Our Health System Partners

- Upper Peninsula Health Care Solutions
- University Hospitals
- Dayton Children’s
- Boston Medical
- Johns Hopkins Medicine
- UCHC
- Upham’s Corner Health Center
- The Dimock Center
- Codman Square Health Center
- Baystate Health
- Contra Costa Regional Medical Center & Health Centers
- Baylor Scott & White Health
- Catholic Health initiatives
- NYC Health + Hospitals
- Henry Ford Health System
- Yale New Haven Health
- Children’s Hospital of Wisconsin
- Norfolk General Hospital
- Children’s Hospital of Wisconsin
- Stanford School of Medicine
- Manet Community Health Center
- Florida Health Pinellas County
The Roadmap to High-Quality Social Needs Interventions

**Patient Identification & Screening**
Which patient population will you target and how will you surface their social needs?

**Navigation & Resource Connections**
For which specific social needs will you offer support?
What level and type of support?

**Community Partnerships**
What Community Based Organizations are critical to the health of your members? How will you continually improve access to resources?

**Social Health Needs Team & Workflow**
Who will provide resource support for patients? How will you integrate this with broader clinical and behavioral processes?

**Data and Evaluation**
How will you know how much to invest in social supports in the long run? How will you know how to maximize the impact of this investment?

**Leadership and Change Management**
Have you identified a social needs champion with the ability to allocate resources?

*Developed by the Leaders Coalition, a group of >20 healthcare systems who came together to identify the core components of high quality social needs programming within the healthcare system in a series of dialogues facilitated by Health Leads.*
Health Leads Screening Toolkit

- Gathered best practices
- Literature review
- Identified validated tools
- Published toolkit
- Iterated upon toolkit
Criteria for Choosing Questions

**Validated**
- Does the question come from a validated instrument?
- Questions are often validated as part of a broader instrument
- How will you validate your complete screening tool?

**Precision**
- Are you looking for a general understanding of prevalence, or a more specific focus?
- What is your workflow for handling positive screens?

**Literacy Level**
- Is the question readable for your patient population?
- Are your questions available in multiple languages?
- How will the screen be administered?
Quick Tips: Choosing Screening Questions

What makes a great screening question?

• Concise
• 5th grade literacy level
• Available in multiple languages that reflect your population
• Strength-based and respectful of patients
• Phrased to allow patients to “opt in” to the resources they desire
State Wide Screening Pilot with North Carolina

SCREENING PILOT GOALS

- Create a standardized set of screening questions to routinely identify unmet resource needs
- Develop training curriculum for staff around screening pilot implementation and standardized collection of pilot data from patients throughout the state
- Test standardized screening questions at pilot clinics to obtain staff and patient feedback on screening questions
- Assess screening questions, including patients’ comfort and understanding of questions
- Identify methods for and barriers in administering the screening questions
State Wide Screening Pilot with North Carolina

Technical Advisory Group determined priority domains
- 1. Food insecurity
- 2. Housing instability
- 3. Lack of transportation
- 4. Interpersonal violence

Reached consensus on screening questions and pilot guidelines

Multi-phase testing
- 741 patients screened at 19 clinic locations
- 63 patients screened over the phone
Key Findings

Screening Tool Assessment Results

- FELT LENGTH OF SCREENING TOOL WAS GOOD: 99% (English speaking patients), 92% (Spanish Speaking patients), 97% (Clinic staff)
- FELT COMFORTABLE WITH SCREENING TOOL QUESTIONS: 94% (English speaking patients), 95% (Spanish Speaking patients), 93% (Clinic staff)
- UNDERSTOOD THE SCREENING TOOL QUESTIONS: 97% (English speaking patients), 90% (Spanish Speaking patients), 100% (Clinic staff)
Key Findings

Need Prevalence and Resource Connection

- Food Insecurity: 42%
- Housing Insecurity: 20%
- Utilities: 9%
- Transportation: 20%
- Interpersonal Violence: 14%

Screened Positive
Wanted a Resource
Sites that previously screened for SDOH saw an increase in their positive screen rate with the new screening tool.

“An interesting find for us is that during the pilot we had a 50% ‘yes’ rate, compared to our normal process where we have only been averaging a 7% ‘yes’ rate. We believe these questions are a little more specific than the ones we currently use.”

One rural FQHC reported that their positive screen rate increased to 35% with the self-administered standardized tool, compared to 1% with the EMR integrated screening tool. Other studies of self-administered screening tool support these findings.
Key Takeaways

• Start small: pilot and test your approach to screening
• Engage key stakeholders and incorporate their perspectives, including patients, providers and staff at every stage of developing, implementing, and improving your screening tool to increase buy-in and drive towards successful adoption
• Have resources available for those who screen positive and want to be connected to a resource
• Standardized screening removes assumptions to uncover need prevalence and can help direct resources where they’re most needed
• Collect and study your screening data to inform improvements and demonstrate impact
Questions?

Michelle Zambrano
mzambrano@healthleadsusa.org
Social Determinants of Health
A health plan perspective

Improving care for people with disabilities and chronic health needs
Member-Centered Care
Commonwealth Care Alliance Members

One Care
Adults 21 – 64 yrs

Dual eligibility
• Medicaid
  MassHealth
• Medicare

• 48.3% of members have four or more chronic conditions
• 72.3% of members have a physical and/or behavioral health disability
• 64.2% have a behavioral health condition such as schizophrenia, bipolar disorder or severe depression
• 30.6% have a substance use disorder
• 8.3% have a major disability such as paralysis, multiple sclerosis/muscular dystrophy/cerebral palsy
• 7.4% are documented homeless
Social Determinants of Health – Data Sources

- **CCA Eligibility**
- **Annual Comprehensive Assessment** – In person (in-home) health history and physical assessment by APC
- **Minimal Data Set** – In person RN
- **Relationship Based Care Partnership**
Annual Comprehensive Assessment

- Immediate needs and current services in place, including preventive health and preferred providers - what is working well and what can be improved
- Health conditions and current medications
- Functional status
- Mental health and substance use
- Accessibility needs
- Transportation access needs
- Housing/home environment
- Informal supports/caregiver supports
- Social supports
- Food security and nutrition
## Minimal Data Set – SDOH Items

<table>
<thead>
<tr>
<th>Race/ Ethnicity</th>
<th>Home setting &amp; household members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>Social Functioning</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Informal Supports</td>
</tr>
<tr>
<td>Education Level</td>
<td>Physical Functioning (meal prep,</td>
</tr>
<tr>
<td>Communication/ Hearing Patterns</td>
<td>bill pay, etc.)</td>
</tr>
<tr>
<td>Vision Patterns</td>
<td>Lifestyle (drinking/smoking)</td>
</tr>
<tr>
<td>Mood &amp; Behavior Patterns</td>
<td>Personal Safety</td>
</tr>
</tbody>
</table>

*InterRAI MDS-HC*
Uncommon Care

Transportation
Phone Support
Technology
Housekeeping
Doula Program

Home Visits

Personal Care Assistance
Education
Housing
Meals
STATEWIDE COLLABORATIVE TO ADDRESS SOCIAL DETERMINANTS OF HEALTH (SDOH)

MARCH OF DIMES HEALTH EQUITY COLLABORATIVE
THURSDAY, MARCH 28, 2019
Describe processes and tools for screening, referral, and tracking social health needs
SESSION FACULTY

Gina Burrows RN, MSN, APRN, NEA-BC
Director, Population Health
Connecticut Hospital Association

Billie-Jo Frazier, MA
Manager, Population Health
Connecticut Hospital Association

No Conflicts to Disclose
A transformative, multi-year initiative to improve healthcare effectiveness, health outcomes, and population health through integration of social determinants of health into healthcare practice.

STRATEGIC GOAL: Coordinate the collaboration among providers and community-based organizations to address social determinants of health and reduce the disparities that lead to poor clinical outcomes.
“I diagnosed ‘abdominal pain’ when the real problem was hunger; I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients’ lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether.”

– Laura Gottlieb, MD, San Francisco Chronicle

Source: https://www.sfgate.com/opinion/oped/article/Funding-healthy-society-helps-cure-health-care-3177542.php
SUGGESTED STEPS TO IMPLEMENT SDOH SCREENING

1. Assess Participants’ Knowledge and Practice
   • Survey for readiness

2. Develop Stakeholder Buy-in – Level Set
   • C-Suite/leadership
   • Front-line staff
   • Community-Based Organizations (CBO), continuum of care partners, others etc.

3. Create Broad-Based Advisory Group of Experts
   • Hospitals
   • CBOs
   • Federally Qualified Health Centers (FQHC)
   • State agencies
   • Physician practices
   • Local health directors
   • Others

4. Choose/Develop Assessment Tool – Research and Compare
   • PRAPARE
   • Health Leads
   • Health Begins
   • CMS
   • CHA Tools
   • https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison

5. Evaluate and Determine Workflow/Process – Create Flowchart
   • Who – staff initiating/performing screening
   • What – screening tool used
   • When – during intake, at discharge, etc.
   • Where – location/space considerations-privacy
   • How – paper or electronic, interview or self-report

6. Prepare/Train Team and Partners – Why Screening is Important
   • Staff
   • Organization
   • CBOs, continuum of care partners, others, etc.

7. Identify Mechanisms for Evaluation
   • Check-in calls
   • Site visits
   • Evaluation surveys
   • Patient stories
   • Data collection

8. Begin Screening – Test for Change
Advisory Group
Hospitals, Federally Qualified Health Centers, local departments of health, health equity policy experts, healthcare faculty, practitioners, community-based organizations, state agencies

- **Provide Education**
  - Health Begins©
  - Collaborative Consulting©
  - Presentations
  - Webinars
1. Please provide your contact information:
   a. Name
   b. Title
   c. Telephone Number
   d. E-Mail Address

2. Please indicate your organization type:
   a. Hospital
   b. Federally Qualified Health Center (FQHC)

3. If a hospital, please select from the drop down menu:
   a. (drop down menu)

4. If an FQHC, please fill in the name of your organization:
   a. Name: ____________________________

5. Does your organization use a specific definition for SDOH?
   a. Yes
   b. No
   c. If yes, please provide the definition: ______________

6. Does your organization identify patients’/clients’ SDOH by using an assessment tool?
   a. Yes
   b. No
   c. If yes, please indicate the assessment tool: _____

7. If yes, where is the assessment tool utilized?
   a. Emergency Department (ED)
   b. Inpatient Unit
   c. Admission Assessment (FQHC)
   d. Outpatient Services
   e. Other, please specify: ________________

8. Who is conducting the assessment:
   a. Social Worker
   b. Case Manager
   c. Staff Nurse
   d. Chaplain
   e. Other, please specify: ________________

9. How often is an assessment completed?
   a. First patient visit to facility only
   b. Each patient visit to facility
   c. Other, please specify: ________________

10. Is there a mechanism in place for referrals?
    1. Yes
    2. No
    3. If yes, please specify: ________________

11. Is there a mechanism in place for follow-up related to specific referrals?
    1. Yes
    2. No
    3. If yes, please specify: ________________

12. What areas are considered in your assessment?
    a. Race/Ethnicity
    b. Age
    c. Language
    d. Housing Insecurity
    e. Income
    f. Employment
    g. Military Service
    h. Transportation
    i. Exposure to Violence
    j. Food Insecurity
    k. Education
    l. Access to Health Services
    m. Sexual Orientation
    n. Disabilities (physical or mental)
    o. Other, please specify: ________________

13. Is there a process for tracking SDOH?
    a. Yes
    b. No
    c. If yes, please specify: ________________

14. Are you aware of 211, an online database for community-based resources?
    a. Yes
    b. No

15. Is there edu/training available to staff about SDOH and resources?
    a. Yes
    b. No
    c. If yes, please specify: ________________
Addressed SDOH through screening, referral, and follow-up in four project hospitals
  - Used process mapping to optimize workflow
  - Units identified varied for each project hospital

Lessons Learned
  - Follow-up was one of the biggest challenges in the workflow process
  - SDOH screening as a standard of practice requires:
    - Culture change
    - Education and facilitative tools
    - Strong partnerships with community-based organizations
**PROCESS MAPPING EXAMPLE**

- **Start**
  - Patient visits clinic for first time as a new patient
  - Patient is provided the screening tool as a part of the new patient process
  - Clinic staff (CS) meets with patient and further explains the tool
  - Patient declines to participate in the screening
  - Data Worksheet is updated to reflect the declined screening

- **Patient completes the screening tool**
  - CS assists the patient in completing the tool
  - CS collects completed tool for evaluation

- **CS reviews screening to identify needs**
  - CS reviews the completed tool
  - CS identifies potential needs
  - CS confirms patient's permission and desire for CBO referral(s)
  - CS educates patient on next steps and addresses any questions

- **CS provides patient with referral to CBO(s)**
  - CS identifies CBO(s) that can meet needs of patient
  - CS provides the patient with CBO information to initiate contact

- **Follow up occurs to ensure patient connected with the CBO and assists as needed**
  - CS/Student contacts the patient within 1 week of the referral to ensure success
  - CS/Student confirms the CBO is capable of delivering requested service/support
  - If needed, patient is offered/provided support in making contact with CBO

- **Follow up occurs to track service delivery to patient**
  - Student/CS contacts the patient/CBO to determine whether services have been provided
  - Continued follow up occurs until necessary information is received

**Data Worksheet is updated to reflect the final results of the referral process**

**Evaluation Expectations:**
- Biweekly Calls with CHA
- Monthly Data Collection
- Final Survey
- Final Survey for CBO Participants
- Patient Experience Feedback
# CONNECTICUT SOCIAL HEALTH INITIATIVE ASSESSMENT TOOL

This form asks you if you need help with things like food, heat, or housing.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Today's Date:</th>
<th>Address:</th>
<th>Telephone Number:</th>
<th>Best Time to Call:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ABOUT YOU

1. Are you Hispanic or Latino?
   - Yes
   - No
   - I do not want to answer.

2. Which race(s) are you? (Check all that apply)
   - Asian
   - Native Hawaiian
   - Pacific Islander
   - Black/African American
   - White
   - American Indian/Alaska Native
   - Other (please write): I do not want to answer.

3. What language are you most comfortable speaking?
   - English
   - Other (please write): I do not want to answer.

## WORK AND RESOURCES

6. What do you do for work?
   - Not working
   - Part-time or temporary work
   - Full-time work
   - Not enough work or too little pay
   - Not looking for work
   - (Why, please write): I do not want to answer.

7. In the past year, what did you or your family go without? (Check all that apply)
   - Food
   - Inexpensive/Other
   - Medication(s)
   - Health Care (like Medical, Dental, Vision)
   - Other (please write): I do not want to answer.

8. Has lack of transportation stopped you from getting to the doctor, to work, or getting things you need every day? (Check all that apply)
   - Yes (please write)
   - No
   - I do not want to answer.

## HOUSING

4. Do you have a place to live today?
   - Yes
   - No
   - I am worried about a place to live
   - I do not have a place to live
   - I do not want to answer

## SCHOOL

5. How long did you go to school?
   - I did not finish high school
   - I finished high school or have a GED
   - I finished more than high school
   - I do not want to answer

Note to hospitals and providers: Obtain and document patient permission before contacting community agencies on patients' behalf.

Segments of this form are used by permission from the National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OIC, Institute for Alternative Futures, The Protocol for Responding to and Assisting Patients' Assets, Risks, and Expenditures (PATH/APEX) Program. 2016. Available from www.aphe.org/apex

The Connecticut Hospital Association Last Revised 12/20/17 - GRADE LEVEL 4.7
1. What are the current tools utilized by your organization and continuum of care partner(s)?
2. What are 3-5 social health needs (domains) in your community/state?
3. What are the critical elements you need to capture; race, ethnicity, gender, etc.?
4. Who is the intended population for screening?
5. Who will be conducting the screening and when?
6. How will you capture screening tool responses?
7. How do you determine a positive screen?
8. What are your community-based organization resources?
9. How will you evaluate the tool (strengths and weaknesses)?
10. How will you collect and track data to identify areas for improvement?
Implement Technology Platform to Support Collaboration

- CMS screening tool
  - Five questions
  - Three domains – Food insecurity, housing instability, transportation
- Vendor selection
- Community-based organization connections
CURRENT PROGRESS

- Social Determinants of Health Advisory Group meetings
- Social Determinants of Health Technology Work Group meetings
- Most hospitals assigned an executive sponsor and collaborative leader
- Education and training provided to hospitals
- CMS screening tool: three domains – food, housing, transportation
- Most hospitals are screening in at least one patient unit
- Most hospitals have identified one or two community-based organizations to connect with initially via the technology platform
Appendix
CHA FIVE QUESTION SCREENING TOOL (CMS)

Food
1. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   — Often true
   — Sometimes true
   — Never true
2. Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.
   — Often true
   — Sometimes true
   — Never true

Housing
3. What is your living situation today?
   — I have a steady place to live
   — I have a place to live today, but I am worried about losing it in the future
   — I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
4. Think about the place you live. Do you have problems with any of the following?
   Choose all that apply:
   — Pests such as bugs, ants, or mice
   — Mold
   — Lead paint or pipes
   — Oven or stove not working
   — Smoke detectors missing or not working
   — Water leaks
   — None of the above

Transportation
5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting to things needed for daily living?
   — Yes
   — No
PRAPARE AND CMS SCREENING TOOLS

**Prepare Screening Tool**

**CMS Screening Tool**
Gina Burrows RN, MSN, APRN, NEA-BC
Director Population Health
Connecticut Hospital Association
burrows@chime.org
(203) 294-7379
DEVELOPMENT PLAN FOR OUTREACH AND PUBLICATION FOR THE BIRTH EQUITY CONSENSUS STATEMENT

Electronic sign-on process continues to draw interest and generate momentum.

• Collaborative members’ word of mouth via announcements and peer sharing
• Highlighting the document during upcoming conferences
• Social media
• Potential for manuscript to generate additional interest and endorsements
• Other ideas??
OPEN DISCUSSION
# ENDORSEMENTS

## ORGANIZATIONS
- American Public Health Association (APHA)
- Palmetto Healthy Start
- CityMatCH
- Commonwealth Care Alliance
- Georgia Obstetrical and Gynecological Society
- Black Women for Wellness
- Trust for America’s Health
- National WIC Association
- Birthing Project USA
- UNC Center for Maternal and Infant Health
- Ancient Song Doula Services
- Zeta Phi Beta Sorority, Incorporated
- North Carolina Perinatal Association
- Black Women’s Health Imperative
- National Institute for Children’s Health Quality (NICHQ)
- Birth Matters
- Nzuri Malkia Birth Collective
- Medicines360

## INDIVIDUALS
- Kay Johnson, Johnson Group Consulting, Inc. Past chair US HHS Secretary Advisory Committee on Infant Mortality (SACIM)
- DeWayne Pursley, MD, MPH; Department of Neonatology, Beth Israel Deaconess Medical Center
- Dr. Steven G. Gabbe, The Ohio State University Wexner Medical Center
- Linda Nelson, University of Minnesota DNP student Public Health Nursing
- Dr. Patricia T. Gabbe, MD, MPH Founder Moms2B, Clinical Professor of Pediatrics, Obstetrics and Gynecology; The Ohio State university College of Medicine and Nationwide Children’s Hospital
- Dr. Allison Bryant, MD, MPH, Massachusetts General Hospital
- Shareece Davis-Nelson
- Robbie Caldwell
- Dr. Ndidiamaka Amutah, Tufts University
## ENDORSEMENTS

<table>
<thead>
<tr>
<th>ORGANIZATIONS</th>
<th>INDIVIDUALS</th>
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<tbody>
<tr>
<td>• March of Dimes</td>
<td>• Charlene Harris</td>
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<td>• Georgia OBGyn Society</td>
<td>• Janine Hill</td>
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<td>• 100 Million Healthier Lives</td>
<td>• Frankie Robertson, March of Dimes</td>
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<td>• Power to Decide</td>
<td>• Terri Major-Kincaide</td>
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<td>• Society for Maternal Fetal Medicine (SMFM)</td>
<td>• Starr Barbour</td>
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<td>• Center for Disease Control and Prevention (CDC)</td>
<td>• Paula Braveman, MD, MPH, Professor of Family and Community Medicine, Director of the Center on Social Disparities in Health, UCSF</td>
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<td>• Northeast Florida Healthy Start Coalition</td>
<td>• Dr. Arden Handler, University of Illinois School of Public Health</td>
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<td>• Michigan Public Health Institute</td>
<td>• Rebecca Smith</td>
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<td>• Health Care Without Walls</td>
<td>• Gloria DeLoach</td>
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<td>• Health Leads</td>
<td>• Shantay Davies-Balch</td>
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<td>• Council on Alcohol &amp; Drug Abuse-CB</td>
<td>• Marilyn Noll</td>
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<td>• Buffalo Prenatal Perinatal Network</td>
<td>• Meredith Yaker</td>
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<td>• American College of Nurse-Midwives (ACNM)</td>
<td>• Shaconna Haley</td>
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<td>• Society for Public Health Education (SOPHE)</td>
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<td>• Generate Health STL</td>
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<td>• Raise Colorado Coalition</td>
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<td>• National Healthy Start Association</td>
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<td>• National Association of Nurse Practitioners in Women's Health</td>
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<td>• National Birth Equity Collaborative</td>
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<td>• Long Island Doula Association</td>
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**TOTAL ENDORSERS:** 59
POLL QUESTIONS

1. In your role, do you screen people for social determinants of health?
2. If you’re not screening, please share reasons why.
3. If you screen, which screening tool do you use?
4. If you screen, is your screening integrated into the health record?
5. If you screen for SDOH, are you being reimbursed?
6. What are your best practices around SDOH screening?
7. Can you suggest other elements that would be helpful in setting up a SDOH screening tool?
8. Have you signed the Consensus statement?
SCHEDULE & EVALUATION
## COLLABORATIVE MEETING SCHEDULE (all times are EST)

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If you are interested in attending the full Collaborative or specific workgroup meetings please email us at collaborative@marchofdimes.org to receive the registration link and specific meeting information. This calendar is subject to change.
JOIN US JULY 8th

Equity in Action: Moving from Theory to Practice

• Registration will open soon
• Join us July 8th in Orlando Florida
• Stay for the NACCHO conference
In the chat box, you will see a link to a brief post-meeting survey that will take you less than 5 minutes to complete. Your feedback is very important to us, so thank you in advance.

The link for the survey is: http://marchofdimes.org/workgroup

Click on the Chat icon in your toolbox to access the survey link.
ADJOURN